Review Of
Community Services Board
Substance Abuse Outpatient Services for Adults

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Office of the Inspector General
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Section I

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Executive Summary

The Office of the Inspector General for Mental Health, Mental Retardation & Substance Abuse Services (OIG) conducted a review of the statewide system of community services board (CSB) substance abuse services during August 2006. This service was selected for review because drug and alcohol abuse and addiction are among the Commonwealth's most serious and complex public health problems, with far reaching consequences for families, employers, social services systems, and the criminal justice system. Approximately 46,000 adults received substance abuse services from CSBs in FY 2005.

To assure that the review focused on current issues, the OIG invited the contribution of ideas from a wide range of stakeholders including consumers, advocates, community providers, and the staff of the Department of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS). The basis for the review was nine Quality Statements for Adult Substance Abuse Services Treatment that were developed by the OIG. The review included a survey to assess the range and capacity of all substance abuse services available in communities served by all 40 CSBs. OIG inspectors also inspected a sample of 25 CSBs, focusing on the one service that is provided in every community: adult outpatient services. During the site visits, interviews were conducted with 195 service recipients, 166 outpatient clinicians, and 73 division directors and supervisors. Approximately 240 service recipient case records were reviewed. A survey was also conducted with the Department of Corrections' 43 local Probation and Parole Offices across the state, as these agencies are the largest referral source for CSB substance abuse services.

Findings and Recommendations

Access to Appropriate Services

A. Comprehensive Services

Access Finding A.1: The range, variety, and capacity of substance abuse services are not adequate to meet the needs of consumers in the majority of Virginia communities.

Access Recommendation A.1.a: It is recommended that DMHMRSAS, with the involvement of CSBs and consumers, conduct a short-term study to:

- Identify the community substance abuse services for which expansion is most needed to improve accessibility to services.
- Quantify the cost for each type of service that is most needed.

It is further recommended that DMHMRSAS request funding to enable the development and expansion of the most needed services.

Access Recommendation A.1.b: It is recommended that DMAS investigate the cost and feasibility of expanding coverage of substance abuse treatment services for Medicaid recipients.

B. Timely Access

Access Finding B.1: It takes an average of 25.4 days after their first call for persons to enter active treatment at Virginia's CSB substance abuse outpatient programs.

Access Recommendations A.1.a and A.1.b are also in support of this finding.

Access Recommendation B.1.a: It is recommended that each CSB review its access procedures to identify ways in which the wait time from initial call or referral to initiation of active treatment can be shortened. It is further recommended that CSBs across the state share innovative access technologies.

Access Recommendation B.1.b: It is recommended that CSBs develop and offer temporary supports and engagement opportunities such as drop-in groups to consumers who must wait for access to ongoing treatment.

Access Finding B.2: Many consumers report that their out-of-pocket expenses for treatment are too costly.

Access Recommendation B.2: It is recommended that each CSB review its fee structure, with the involvement of consumers, to assure that current policies do not serve as a barrier to access to services.

Quality of Care

C. Consumer-Centered Services

Quality of Care Finding C.1: Substance abuse service users and staff agree that consumers play a key role in developing their own service plans, however, clinical records do not fully reflect this.

Quality of Care Recommendation C.1.a: It is recommended that DMHMRSAS and CSBs, including substance abuse clinician representatives and consumers, develop a model service planning system and format that is person-centered, reflects the principles of recovery, and meets all regulatory requirements.

Quality of Care Recommendation C.1.b: It is recommended that DMHMRSAS initiate a collaborative effort with CSBs and consumers to develop a training program on person-

centered planning in substance abuse services, using the model service system and format, and that this training be made available widely to CSBs and regional groups.

Quality of Care Finding C.2: Gaps and limited capacity in the array of substance abuse services available in most Virginia communities restrict consumer choice and do not allow sufficient individualization of treatment programs.

Access Recommendations A.1.a and A.1.b are also in support of this finding.

D. Treatment environment

Quality of Care Finding D.1: CSBs provide a welcoming and supportive service environment according to consumers and the principal referral source, the Probation and Parole offices.

No recommendation

E. Helping Relationship

Quality of Care Finding E.1: CSB substance abuse service providers and the persons they serve experience reliable, trusted, and caring relationships.

No recommendation

Quality of Care Finding E.2: Staff are employed in their current positions long enough to form trusted, continuing relationships with the consumers they serve.

No recommendation

F. Co-occurring Disorders

Quality of Care Finding F.1: The mental health needs of persons receiving CSB substance abuse outpatient treatment for adults appear to be under assessed and under treated.

Quality of Care Recommendation F.1.a: It is recommended that DMHMRSAS provide leadership, guidance, and training to CSBs for the development of integrated treatment models for co-occurring mental health and substance abuse disorders.

Quality of Care Recommendation F.1.b: It is recommended that CSBs study their systems of care to assure maximum integrated response to co-occurring disorders.

Quality of Care Recommendation F.1.c: It is recommended that DMHMRSAS study the extent to which the administrative separation at the state level creates barriers to an integrated response to co-occurring disorders at the provider level.

Quality of Care Finding F.2: Access to psychiatric services and medications for adults receiving substance abuse outpatient treatment services is severely limited at CSBs.

Access Recommendations A.1.a and A.1.b are also in support of this finding.

Quality of Care Recommendation F.2.a: It is recommended that DMHMRSAS lead an initiative that will enable a sharing of psychiatric resources between state facilities and CSBs. This will result in maximizing the effectiveness of physicians who are already in the public provider system and will enhance the continuity and quality of care provided in facilities and in the community.

Quality of Care Recommendation F.2.b: It is recommended that DMHMRSAS establish guidelines to enable substance abuse consumers who have been identified by CSBs as indigent to access free or reduced cost medications through the DMHMRSAS Community Pharmacy.

G. Case management

Quality of Care Finding G.1: Consumers of substance abuse services face severe shortages of core services needed for successful recovery in the community – affordable housing, reliable transportation, employment assistance, etc. Very few CSB substance abuse outpatient consumers receive adequate case management assistance.

Access Recommendation A.1.a is also in support of this finding.

Quality of Care Recommendation G.1.a: It is recommended that DMAS investigate the cost and feasibility of covering case management for substance abuse consumers who are Medicaid recipients, focusing particularly on women with children

Quality of Care Recommendation G.1.b: It is recommended that DMHMRSAS, working with CSBs, develop a model training curriculum on substance abuse case management and provide training on this topic to CSB staff and supervisors.

H. Staff qualifications and support

Quality of Care Finding H.1: CSB substance abuse staff has appropriate education and training for their positions.

Quality of Care Recommendation H.1.a: It is recommended that DMHMRSAS initiate a collaborative effort with CSBs and consumers to develop training curricula in the following topics and make these programs available to all CSBs:

- Person-centered service planning (See Recommendation C.1.a and C.1.b)
- Provision of integrated treatment for those with co-occurring mental health and substance abuse disabilities. (See Recommendation F.1.a)
- Case management for persons with substance abuse (See Recommendation G.1.b)

Quality of Care Recommendation H.1.b: It is recommended that each CSB evaluate the training needs of substance abuse treatment staff and take steps to assure that adequate training is made available.

I. Services effectiveness

This OIG review did not attempt to evaluate the service effectiveness indicator of quality. However, data were collected that show that CSB substance abuse outpatient programs for adults receive positive evaluations from consumers and P&P offices.

Survey of Probation and Parole Offices

The majority of persons served at CSB substance abuse programs have violated the law. Crime and substance abuse are paired. Research has shown that combining criminal justice sanctions with drug treatment can be effective in decreasing drug use and related crime (National Institute on Drug Abuse). This review includes the results of a survey of the 43 Virginia P&P offices through which the OIG gathered information about the quality of services provided by the CSB substance abuse outpatient services for adults.

Section II

Background of the Study

About the Office of the Inspector General

The Office of the Inspector General (OIG) is established in the VA Code § 37.2-423 to inspect, monitor and review the quality of services provided in the facilities operated by the Department of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS) and providers as defined in VA Code § 37.2-403. This definition includes all providers licensed by DMHMRSAS including community services boards (CSB) and behavioral health authorities (BHA), private providers, and mental health treatment units in Department of Correction facilities. It is the responsibility of the OIG to conduct announced and unannounced inspections of facilities and programs. Based on these inspections, policy and operational recommendations are made in order to prevent problems, abuses and deficiencies, and to improve the effectiveness of programs and services. Recommendations are directed to the Office of the Governor, the members of the General Assembly and the Joint Commission on Healthcare.

Selection of Community Outpatient Substance Abuse Services for Review

Substance abuse outpatient services for adults was selected by the OIG for review for the following reasons:

- Substance abuse and addiction to alcohol and drugs are among the nation's most serious public health problems.
    - Offender drug abuse is involved in more that half of all violent crimes and in 60-80 percent of child abuse and neglect cases.
    - 70 percent of all persons in state and local correctional facilities and jails have abused drugs regularly.
    - The estimated cost to society of drug abuse in 2002 was $181 billion. Of this total, $107 billion was associated with drug-related crime.
- DMHMRSAS, using data from the National Household Surveys on Drug Use and Health, estimates that 5.46 percent of the Virginia population aged 12 or older – 335,545 persons - are substance dependent (2003 Final Estimated Population data).
- Research is demonstrating that treatment for drug-addicted offenders can have a positive effect upon future drug use, criminal behavior, and social functioning. It is estimated that every dollar invested in addiction treatment programs yields a return of $4 to $7 for reduced drug-related crimes.
- CSBs in Virginia served 45,912 adults in substance abuse programs overall and 30,748 adults in substance abuse outpatient services during FY2005.
- Concern exists that substance abuse programs have lost service capacity in recent years due to decreases in state funding. These programs are reliant primarily on state and federal tax sources with little access to third party funding such as Medicaid.

- CSB substance abuse programs are critical to the work of state and local criminal justice agencies and the courts. The majority of those who receive these services are mandated to receive treatment by the courts or other authorities.
- Recovery, consumer empowerment and self-determination have been identified by DMHMRSAS as critical principles to guide the public mental health, mental retardation and substance abuse service delivery system. It is not known to what degree these values are reflected in the provision of substance abuse services.
- Concern exists that the lack of case management services available to consumers with substance abuse problems impedes successful achievement of their recovery goals.

Design of the Review

The OIG established two objectives for this review. (1) To describe the range and capacity of substance abuse services currently available from or through Virginia's CSB system. (2) To conduct an intensive review of substance abuse outpatient services for adults, the one service that is currently provided by all CSBs.

The OIG began the study process by conducting an extensive literature search of indicators of quality and other issues in substance abuse services. A member of the OIG staff attended a July 15 conference on integration of mental health and substance abuse services presented by Kenneth Minkoff, M.D. and Christine Cline, M.D., and received consultation from the presenters about studying co-occurring substance abuse and mental health needs and services.

A telephone conference was hosted by the OIG on July 12, 2006, with participation by over 30 CSB representatives – executive directors and substance abuse services directors. A representative of the advocacy group Substance Abuse and Addiction Recovery Alliance (SAARA) also participated. A number of CSBs provided additional written commentary and resources following the teleconference.

Input to the design of the review was received from DMHMRSAS leadership and central office staff, including the Office of Substance Abuse Services.

Input was also sought from the state Department of Corrections (DOC). This enabled the OIG to gain access to the perspective of local probation and parole offices that refer individuals to CSBs for substance abuse treatment and often have service agreements or contracts with the CSBs.

A group discussion was held with 18 substance abuse service consumers at the Region Ten Community Services Board on July 27. Consumers were asked to identify issues of quality from their perspective. A similar session was held with direct service staff and supervisors.

Many expressed the opinion that the term "substance use disorders" is preferred over substance abuse. However, a consensus does not yet exist within the field and the major state and federal offices still retain use of the term substance abuse. For these reasons, the term substance abuse has been used in this report.

Quality Statements for Adult Outpatient Substance Abuse Treatment Services

The OIG developed a set of nine quality statements for adult substance abuse outpatient services from the research and input described above:

1. A wide range of substance abuse services is available to meet the varied and changing needs of people in different stages of addiction and recovery, and services are matched to the specific needs and level of recovery of the persons served.
2. Substance abuse services are readily available and affordable.
3. Substance abuse services support the consumer's role in managing his or her own recovery.
4. Consumers seeking services encounter a welcoming, supportive environment and feel supported and valued by the people providing services.
5. Consumers and substance abuse staff share an interpersonal helping connection that has continuity and fosters trust and support for each consumer's recovery.
6. The substance abuse and mental health needs of consumers are assessed and addressed in an integrated, inclusive, comprehensive manner.
7. Persons in recovery receive case management services when needed for housing, transportation, employment, childcare, and other supports.
8. Substance abuse staff has appropriate education, training, and supervision for their roles.
9. Consumers show progress in recovery due to services that are objectively measured to be effective.

Development of survey instruments

OIG staff developed survey instruments that addressed each of the quality statements, many from more than one point of view. Where possible, these interview instruments were based on questionnaires or other evaluation tools supported by published research.

The instruments and the review process were field tested with staff and supervisors at the Region Ten Community Services Board on August 4. Feedback for the improvement of questionnaires was received and changes were made. The OIG is grateful to the consumers and staff of the Region Ten Community Services Board for their assistance in helping to prepare for this study.

All survey questionnaires and checklists can be found in the Appendix in the version of the report that is located on the OIG website (www.oig.virginia.gov).

Process of the review

A sample of 25 of the 40 CSBs was selected for the study using a technique best described as stratified or proportionate random sampling. In this approach, assurances were made to represent all regions of Virginia, both rural and urban. The resulting sample of 25 CSBs provided geographic and demographic comparability to the Commonwealth as a whole. CSBs serving a total of 4.37 million persons or 58.5 percent of the population of Virginia were included in the sample.

On July 6, 2006, the Inspector General announced the review and invited representatives to participate in the July 12 input session. On July 13 each CSB was asked to submit the name of a substance abuse contact person, a listing of major outpatient service delivery sites, a schedule of substance abuse treatment groups, and the names of all substance abuse outpatient clinicians. The CSBs were also asked to inform staff and consumers of the review and that OIG staff might visit their CSB to review treatment records, visit a treatment group to interview consumers, and interview staff. Consumers were assured that the Code of Virginia authorizes these activities and that they may choose to decline to participate if they wished.

Two of the 25 CSBs in the sample provide some of their adult outpatient substance abuse services through contract with private providers. In these cases the CSB was requested to coordinate the visit with the private contractor and participate in the study as the responsible party for the provision of that service. OIG staff interviewed both CSB and private agency staff. In this report, references to CSB programs are inclusive of the two CSBs that use private providers.

Overall service availability – With valuable input from CSB and DMHMRSAS substance abuse staff, the OIG developed a survey to assess the range and capacity of substance abuse services in Virginia communities. This "Continuum of Substance Abuse Treatment Services – Survey of Community Services and Capacity" was sent to each CSB on August 29, with a request that the form be completed and returned by September 7.

Referring agency satisfaction - A survey was also developed to assess the satisfaction of the 43 local Probation and Parole (P&P) Offices of the Virginia DOC. Over 60% of the referrals to CSBs for substance abuse services are made by criminal justice agencies, with the vast majority coming from P&Ps. All local P&P chiefs were asked to rate the quality of the substance abuse outpatient services provided by the local CSBs. Survey topics included access to services, cooperation between staff, professionalism of staff, and other quality measures drawn from the literature and input to the study. These surveys were emailed to the chiefs on July 17 with a due date of August 1.

Access to services - A series of questions was developed to assess how persons gain access to a CSB's substance abuse services and how long this process takes from first call to the start of active treatment. These questions were administered to supervisors during the on site inspections at 25 CSBs and by telephone for the remaining 15 CSBs. CSB substance abuse treatment staff, consumers receiving services, and the local P&P office chiefs were asked the same questions concerning average time required to access services.

On site inspections - From August 6 to August 29, site visits were made by the OIG to the 25 CSBs. A single inspector conducted the inspection at the majority of CSBs. Cathy Hill, John Pezzoli, Jim Stewart, and part-time consulting staff Jonathan Weiss and Ann White comprised the project team. John Pezzoli served as project manager; Cathy Hill conducted data analysis and designed charts and tables; and Stevie Burcham assisted with data entry and other duties.

Each CSB received an email notification from the OIG five days in advance of the selected site visit date. This message: 1) announced the date of the inspection, 2) described the schedule for

the day, 3) identified the names of up to eight substance abuse clinicians to be interviewed who were selected at random by the OIG, 4) provided instructions to the CSB on random selection of 12 records for review, and 5) identified a treatment group at which the OIG staff would interviews consumers. All visits were completed in a single day, except for Fairfax-Falls Church CSB, which received a two-day visit.

Site visits included interviews of the outpatient site supervisor and the division director who is responsible for substance abuse services. The OIG inspector reviewed nine records drawn at random from a batch of 12 records that had been gathered by the CSB in advance using criteria provided by the OIG.

Separate group interview sessions were held with consumers and substance abuse outpatient clinicians, usually around eight persons per group. In the group interviews, OIG staff administered an anonymous pencil and paper questionnaire completed by each person. After the questionnaires were completed and collected, the OIG staff led group discussions. Usually the treatment group was in the evening.

Study summary data - The following summarizes the scope of the statewide review of substance abuse outpatient services for adults:

- 40 CSBs (of 40) completed the "Continuum of Substance Abuse Treatment Services Survey."
- 40 (of 43) local Probation and Parole Offices completed the "Survey Regarding CSB Adult Substance Abuse Outpatient Services."
- 195 consumers receiving substance abuse outpatient treatment services were interviewed
- 166 substance abuse outpatient clinicians were interviewed.
- 239 service recipient case records were reviewed.
- 73 division directors and substance abuse outpatient supervisors were interviewed.

Section III

Findings and Recommendations

The findings and recommendations from this review of the CSB Outpatient Services for Adults have been organized into two groupings – those that relate to **Access to Appropriate Services** and other findings that relate to other aspects of **Quality of Care**. The findings and recommendations that follow have been grouped according to the nine Quality Statements for Adult Outpatient Substance Abuse Treatment Services found in Section II of this report.

Access to Appropriate Services

A. Comprehensive Services

A complete array of services, from less intensive to more intensive, is needed to fully meet the individualized needs of men and women in various stages of substance abuse and addiction, as they move through recovery.

Access Finding A.1: The range, variety, and capacity of substance abuse services are not adequate to meet the needs of consumers in the majority of Virginia communities.

- The OIG "Continuum of Substance Abuse Treatment Services – Survey of Community Services and Capacity" called for each CSB to identify which substance abuse services are available to consumers. This survey that was completed by 100% of the 40 CSBs revealed the following regarding major service deficiencies:
  - Half of CSBs lack local social detoxification service. A quarter lack local medical detoxification services.
  - Half of CSBs lack any access to opiate maintenance treatment, yet opiates are frequently seen in 65 percent of communities and they lead the list of all drugs considered by CSB staff to be increasing in use.
  - Only a quarter of CSBs have long-term residential treatment, and almost all have inadequate capacity to meet needs.
  - Residential treatment is generally poorly available, averaging less than 50 percent availability, with even lower capacity.
  - Two-thirds of CSBs report that they have inadequate case management services.
  - While some new medications offer promise for helping to treat addiction by reducing cravings, only half of CSBs have begun to employ them.
- The following table displays a comprehensive continuum of community substance abuse services. For each service, the number of CSBs that report the availability of the service is listed as well as the number of CSBs that report inadequate capacity. The shaded areas identify services for which 70% or more of CSBs have inadequate or no capacity.

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Substance Abuse Services Continuum (Shaded areas identify services for which 70% or more of CSBs report inadequate or no capacity)	**# of CSBs With Service**	**# with Inadequate Capacity**
Detoxification Services		
Medical Detox- withdrawal from drugs in an inpatient, residential or outpatient setting under medical supervision with the use of medications	31	25
Social Detox - withdrawal from drugs in a residential or outpatient setting without the use of medications	21	14
Medically Assisted Outpatient Treatment		
Agonist Treatment - Outpatient treatment of opiate addicts using synthetic opiate such as Methadone	20	12
Partial Agonist - Outpatient treatment of opiate addicts using Buprenorphine	16	13
Medically Assisted Outpatient Treatment- medications that reduce cravings or produce negative symptoms related to use	18	15
Outpatient Treatment- Drug Free		
Day Treatment - Intensive, 5-7 days a week, over 2 hours per day	10	4
Intensive Outpatient - Intensive, 3-4 days a week, 1-2 hours per day	25	14
Group – 1-2 times a week, 1-2 hours a day	40	19
Individual - 1-2 times a week	40	27
Psycho-Educational Group- Such as ASAP Level I	36	13
Family Support Therapy - Support and educational services	33	19
Aftercare and Follow-up - Ongoing, recurring support	34	20
Case management - Ongoing outreach assistance	38	27
Services to Persons in Criminal Justice System		
Jail or prison based services- Intensive services for incarcerated persons	25	20
Community based treatment - outpatient treatment contracted by P&P at the CSB or Probation Office	35	20
Drug Court - Diversion and treatment for convicted persons	21	13
Residential Services		
Long Term -24 hours, 6-12 months		
Men	10	9
Women	10	10
Women and Children	12	8
Short Term - 24 hours, 1-6 months		
Men	27	19
Women	26	20
Women and Children	16	10
Halfway House- partially supervised and transitional		
Men	19	14
Women	14	11
Women and Children	7	5
Oxford House - Resident supported, unsupervised group living		
Men	19	15
Women	14	10
Women and Children	5	4
Subsidized Individual Apartment Living - may have staff supports or case management	15	11

- CSB division directors and supervisors repeatedly expressed a concern that state funding for community substance abuse services has been reduced in recent years and that the lack of third party reimbursement sources such as Medicaid has prevented filling the service gaps created by the loss of state funds.
- In addition to asking CSBs whether or not a comprehensive continuum of services is available in their community, the OIG asked CSBs to identify all services for which capacity had decreased in the last six years. For the following services, over 25 percent of CSBs report a decrease in service capacity over the past six years:
    - Medical Detox
    - Day Treatment
    - Intensive Outpatient
    - Group
    - Individual
    - Educational/Orientation Groups
    - Family Support and Therapy
    - Jail or prison based services for persons in criminal justice system
    - Community based services for persons in the criminal justice system
    - Long term residential services for women
    - Short term residential services for men and women

  For a detailed listing of CSB service capacity reductions in the past six years as reported by CSB staff, please see the Appendix.

Access Recommendation A.1.a: It is recommended that DMHMRSAS, with the involvement of CSBs and consumers, conduct a short-term study to:

- Identify the community substance abuse services for which expansion is most needed to improve accessibility to services.
- Quantify the cost for each type of service that is most needed.

It is further recommended that DMHMRSAS request funding to enable the development and expansion of the most needed services.

DMHMRSAS Response: *DMHMRSAS will develop a study team which will consist of staff from the Office of Substance Abuse Services, representatives of the Mental Health and Substance Abuse Council of the Virginia Association of Community Services Boards, Governor's Substance Abuse Services Council and the Substance Abuse Advocacy Community to review the current availability of substance abuse treatment services, the wait times for these services, and gaps in the continuum of care. This information will allow for the development of a continuum of care model. The level of need for each service will be based on population and identified gaps in the continuum.*

Target date: DMHMRSAS will complete the study by June 30, 2007 and make funding recommendations for inclusion in the 2008-2010 biennium budget.

Access Recommendation A.1.b: It is recommended that DMAS investigate the cost and feasibility of expanding coverage of substance abuse treatment services for Medicaid recipients.

DMAS Response: *DMAS prepared an estimate of the costs of adding certain substance abuse services for adults and children to the Virginia State Plan in August 2005. The cost of adding crisis services, day treatment, intensive outpatient, and case management services was estimated to be $5.5 million in State General Funds. An additional $5.5 million would be obtained through federal participation (FPP). The cost of providing case management services was not individually estimated.*

The 2003 Appropriation Act removed the appropriated funding for substance abuse services. This decision was made in response to Virginia's budget deficit. Funding for substance abuse services was eliminated rather than eliminate or decrease funding for a service that was already in the State Plan and being provided to Medicaid recipients. DMAS is receptive to adding coverage for substance abuse services when funding is allocated for these services.

DMHMRSAS Comment: *DMHMRSAS supports this recommendation and will work collaboratively with DMAS to address this recommendation.*

B. Timely Access

Persons who finally make the move to seek help for their drug or alcohol problems must be taken into care immediately. The overpowering clutch of addiction and its related component of denial, make delay in accessing treatment a major barrier to recovery.

Access Finding B.1: It takes an average of 25.4 days after their first call for persons to enter active treatment at Virginia's CSB substance abuse outpatient programs.

- Consumers, CSB clinicians and supervisors and P&P Chiefs were asked to estimate the average length of time between consumers' initial telephone call or P&P referral and the initiation of active treatment. Average times are listed in the chart below:

WAIT TIME (DAYS) FOR OUTPATIENT SERVICES	
Respondents	**Average Time Estimate**
CSB Consumers	**25.2**
CSB Staff	**25.8**
CSB Supervisors	**23.6**
Probation and Parole Offices	**28.8**
STATEWIDE AVERAGE*	**25.4**

*Total average of all reported estimates from all sources in the study.

- The chart that follows provides average length of time between consumers' initial telephone call to the initiation of active treatment. Estimates are by staff, consumers, and supervisors at the 25 boards inspected by the OIG. To obtain this information for the remaining 15 CSBs, the OIG conducted telephone interviews with supervisors.

WAIT TIME (DAYS) FOR OUTPATIENT SERVICES BY CSB*		
CSB	**Average Of Responses Of CSB Supervisors And Staff****	**Average Of Responses Of CSB Consumers**
Alexandria	30	19
Alleghany Highlands	15	15
Arlington	21	
Blue Ridge	31	24
Central Virginia	6	16
Chesapeake	21	
Chesterfield	38	44
Colonial	31	16
Crossroads	65	15
Cumberland Mountain	15	20
Danville-Pittsylvania	14	
Dickenson	30	
District 19	16	6
Eastern Shore	21	
Fairfax-Falls Church	59	52
Goochland-Powhatan	30	
Hampton-Newport News	10	10
Hanover County	10	
Harrisonburg-Rockingham	25	8
Henrico Area	6	15
Highlands	15	8
Loudoun	30	
Middle Peninsula-NN	27	17
Mt. Rogers	21	
New River Valley	24	15
Norfolk	27	18
Northwestern	20	
Piedmont	6	2
Planning District One	10	59
Portsmouth	18	28
Prince William	11	8
Rappahannock Area	24	49
Rappahannock-Rapidan	21	
Region Ten	14	
Richmond Behavioral H. A.	16	38
Rockbridge	55	70
Southside	10	
Valley	42	
Virginia Beach	34	20
Western Tidewater	40	
STATEWIDE AVERAGE	**25**	**25**

* Wait time is the number of days between the first call by the consumer and the initiation of active treatment,

* * Shaded areas represent CSBs not visited. For each of these CSBs this information was collected by telephone from a substance abuse supervisor but consumers were not interviewed.

- Consumers, staff, and P&P offices concur that delays in receiving treatment that are longer than a few days are clearly contra-indicated, confirming the findings in the literature, input from experts, and national best practices. Long delays severely reduce motivation for treatment and limit access to treatment.
- P&P offices list timely access to treatment as the weakest point for CSB substance abuse services. An item on the survey that read, "The CSB is able to accept new referrals into treatment with little delay." received the highest negative rating of any quality measure.
- Uniformly, CSB staff and supervisors attribute the waiting time to inadequate resources that prevent the offering of more treatment options.
- Some CSBs offer immediate, voluntary access to daily or two-three times weekly "drop in" or waiting list groups. While not ongoing, active treatment, such arrangements offer opportunities for consumers to receive supports and engagement while waiting for treatment.

Access Recommendations A.1.a and A.1.b are also in support of this finding.

Access Recommendation B.1.a: It is recommended that each CSB review its access procedures to identify ways in which the wait time from initial call or referral to initiation of active treatment can be shortened. It is further recommended that CSBs across the state share innovative access technologies.

DMHMRSAS Comment: *DMHMRSAS supports this finding and will work collaboratively with the CSBs to address this recommendation. The Office of Substance Abuse Services (OSAS) will also assist CSBs in identifying innovative approaches and will make this information available to all CSBs.*

Access Recommendation B.1.b: It is recommended that CSBs develop and offer temporary supports and engagement opportunities such as drop-in groups to consumers who must wait for access to ongoing treatment.

DMHMRSAS Comment: *DMHMRSAS supports this finding and will work collaboratively with the CSBs to address this recommendation. In addition DMHMRSAS will develop a budget demonstration proposal for peer run drop in centers. Peer-run programs are grassroots, self-help programs led by and for people in substance abuse recovery. Their purpose is to help individuals and families who are suffering from addiction problems. They serve as information and referral resources for those seeking treatment and recovery. They may also provide social detoxification services as well as transitional housing for individuals in recovery returning to the community. These Programs provide a safe drug and alcohol free environment that provides encouragement and support, camaraderie and fellowship.*

Target date: DMHMRSAS will complete the funding proposal for inclusion in the 2008-2010 biennium budget.

Access Finding B.2: Many consumers report that their out-of-pocket expenses for treatment are too costly.

- All CSBs adjust charges based on income. Required self-pay minimum fees vary greatly among CSBs.
- Treatment is provided under contract with P&P at 48 percent of CSBs and is therefore free to consumers served through the contract. No such support exists at 52 percent of CSBs.
- Virtually no CSB substance abuse consumers have a third party source of payment, apart from the P&P contracts. Few substance abuse consumers qualify for Medicaid, and Medicaid does not cover substance abuse treatment unless it is co-occurring with mental illness or for certain services to pregnant women.
- Even with reduced fees based on income, the costs of intensive treatment can add up. Some clients report that the total weekly cost of CSB treatment, including urinalysis screening charges, can be $30-$60 or more.
- Consumers gave the affordability of fees the second highest unsatisfactory rating of the service satisfaction scale, with 43 percent saying they are only "somewhat satisfied" or "not satisfied" with this aspect of care. As the overall consumer satisfaction with CSB services is generally quite high, this finding stands out.
- P&P offices rated fairness of fees somewhat lower than other qualities of CSB services.

Access Recommendation B.2: It is recommended that each CSB review its fee structure, with the involvement of consumers, to assure that current policies do not serve as a barrier to access to services.

DMHMRSAS Comment: *DMHMRSAS supports this finding and will work collaboratively with the CSBs to address this recommendation.*

Quality of Care

C. Consumer-Centered Services

An important indicator of quality in all substance abuse, mental health, mental retardation services is the degree to which the consumer is involved in developing the treatment plan and is a partner in the conduct of services

Quality of Care Finding C.1: Substance abuse service users and staff agree that consumers play a key role in developing their own service plans, however, clinical records do not fully reflect this.

- The OIG asked consumers and staff the following question to gain an understanding of the consumer's role in developing the individual service plan. The same points were assessed in the records.

Consumer Involvement in the Development of Individual Treatment Plans and Goals			
Which of these statements best describe how consumers' plans and goals are developed?	**Consumer Responses**	**Staff Responses**	**OIG Findings from SA Records**
Staff develop individual services plan (ISP) for the consumer, explain it, and ask consumer to sign it.	21%	11 %	64%
Staff involve the consumer in developing the ISP, inviting the consumer to help create goals. It is done together and the consumer has a say in it.	44%	75%	36 %*
Consumers substantially lead the development of their own need assessment and ISP, in their own words, with staff supports.	35%	14%	

* Responses in the bottom two categories were combined for the record review because the *degree of consumer direction* could not be evaluated objectively in most records.

- Mandated treatment *ipso facto* limits consumer choice and self-determination. However, research has shown that treatment does not need to be voluntary to be effective. Sanctions or enticements can increase significantly both treatment entry and retention rates (National Institute on Drug Abuse).
- The majority of consumers served at CSB substance abuse programs (66 % of the records reviewed) are receiving treatment under some form of court order or external requirement. Their involvement in treatment is not completely voluntary. Mandated treatment often includes specific requirements that further limit consumer and clinician choice (e.g., mandatory testing and reporting of results to the referring agency).
- The majority of consumers (79%) report that they believe they play a significant role in the development of their own service plan either by participating with the staff or taking the lead.

- In the consumer interview, 76 percent of consumers said they were "satisfied" that the "staff helped them develop long term personal recovery plans."
- An even larger percentage of staff (89%) report that consumers are significantly involved in developing the plans. Interviews and observed interactions suggest that staff are aware of the importance of consumer involvement in their own recovery.
- OIG review of records, however, did not reveal similar evidence of consumer involvement. Only 36 percent of the records reviewed had evidence of consumer involvement in development of their plan and the conduct of treatment. Triggers for OIG staff to judge records as having consumer involvement included explicit reference to consumer involvement in the process, statements of consumers' preferences or input in their own language, avoidance of prescriptive language such as "client will remain abstinent," and dedicated sections or pages that allow explicit consumer participation.
- Substance abuse treatment records predominantly reflect group treatment, often with similar, if not identical treatment plans, reducing the individualization and consumer direction of treatment.
- Many of the records reviewed make use of standardized or computer-based forms and documentation templates, even when hand-written. Such formats tend to minimize the opportunity to report individualization and consumer direction. They also allow little detail about the therapeutic relationship.

Quality of Care Recommendation C.1.a: It is recommended that DMHMRSAS and CSBs, including substance abuse clinician representatives and consumers, develop a model service planning system and format that is person-centered, reflects the principles of recovery, and meets all regulatory requirements.

DMHMRSAS Response*: DMHMRSAS will develop a workgroup which will consist of staff from the Office of Substance Abuse Services, representatives of the Mental Health and Substance Abuse Councils of the Virginia Association of Community Services Boards, the DMHMRSAS Licensure Office and the Substance Abuse Advocacy Community and coordinate it's activities with the Case management Workgroup identified in recommendation A.1 of the Inspector General's Review Of Community Services Board Mental Health Case Management Services for Adult and that is highlighted in recommendation G.1.b of this report.*

Target date: Convene Workgroup by November 15, 2006. Preliminary recommendations regarding model, curriculum and necessary resources by August 1, 2007

Quality of Care Recommendation C.1.b: It is recommended that DMHMRSAS initiate a collaborative effort with CSBs and consumers to develop a training program on person-centered planning in substance abuse services, using the model service system and format, and that this training be made available widely to CSBs and regional groups.

DMHMRSAS Response: *DMHMRSAS plans to issue a Request for Proposal that will include development and delivery of curricula to support evidence-based and consensus-based practices that promotes person centered planning in substance abuse services. DMHMRSAS will coordinate these efforts with existing person centered planning activities*

active within the Office of Mental Retardation. The Person Centered Leadership Team met on October 18 to initiate this effort.

Target date: Preliminary recommendations by August 1, 2007

Quality of Care Finding C.2: Gaps and limited capacity in the array of substance abuse services available in most Virginia communities restrict consumer choice and do not allow sufficient individualization of treatment programs.

- Access finding A.1 in this report shows that most communities have major gaps in the array of substance abuse services that are available. Research shows that the creation of service plans based on individual needs and matched with a full range of evidence-based practices improves the likelihood of positive outcomes (*Addiction Treatment Matching,* Research Foundations of the American Society of Addiction Medicine Criteria – 2003).
- In reviewing case records, OIG staff noted a relatively narrow range of available services and reliance on only a few treatment modalities, resulting in treatment plans that were similar, if not identical, regardless of consumers' needs.
- While group treatment is appropriately the dominant treatment modality, relatively little access is available to individual treatment – a highly desirable adjunct therapy. Provision of more individual treatment opportunities was the second most often substance abuse treatment need specified by consumers.
- Many consumers complained about inadequate specialization of treatment groups or of boredom with issues that do not pertain to their own situation.
- Staff and supervisors listed needs for a much wider and more varied range of service offerings for the persons they serve.

Access Recommendations A.1.a and A.1.b are also in support of this finding.

D. Treatment environment

National best practice models emphasize acceptance, warmth, engagement, and encouragement. Helping persons identify and develop their own motivation to recover is a fundamental clinical principle.

Quality of Care Finding D.1: CSBs provide a welcoming and supportive service environment according to consumers and the principal referral source, the Probation and Parole offices.

- As revealed in the chart that follows, consumers at CSBs rated the services they receive very highly on variables designed to measure the degree to which the environment is welcoming and supportive.

Consumer Satisfaction With CSB Substance Abuse Service Variables			
	Satisfied	Somewhat Satisfied	Not Satisfied
The agency has been welcoming and supportive from the start.	83%	16%	1%
Staff treat consumers with dignity and respect.	83%	14%	3%
Staff show hope and belief that consumers can recover from addiction.	87%	10%	3%
Staff are sensitive to consumers' ethnic and cultural background.	89%	8%	3%
The rules and policies of the programs are fair.	69%	27%	4%
Staff explain rights and responsibilities.	85%	13%	2%
The treatment facility is clean and safe.	91%	21%	0%

- Consumers were asked to list the things they value most about the services they receive from the outpatient substance abuse treatment agency. The items most frequently mentioned related to comfort with staff, group settings (support from peers), and the freedom to "open up and talk about problems."
- In interviews, consumers repeatedly praised the comfort and accepting nature of the treatment milieu, often contrasting it to that of the correctional system, including substance abuse services offered by P&P offices.
- P&P offices reported similar assessments of the welcoming environment that their clients encounter when served at CSBs. Sixty- six percent gave positive ratings to a statement that said, "My clients report that CSB staff are caring and supportive." Sixty-seven percent responded positively to a statement that CSB staff treats their clients "with dignity and respect."
- The somewhat lower satisfaction rating for the fairness of rules and policies most often related to strict attendance requirements, urinalysis policies, and the reporting of these items to the referring agencies, which can carry the consequence of parole violation and a return to incarceration. Most of these are external treatment mandates from the referring criminal justice agencies.
    - Many consumers with felony backgrounds reported difficulty in managing the combination of their parole requirements (regular and random reporting and drug testing), treatment responsibilities (two or three groups a week), employment needs, community service and restitution obligations, AA/NA meeting requirements, etc.
    - Complaints about schedules of treatment, conflicts with employment and other responsibilities led the list of "least valued' aspects of treatment as reported by consumers.

No recommendation

E. Helping Relationship

Effective treatment requires that consumers and substance abuse staff share a constructive interpersonal helping connection that has continuity and fosters trust, cooperation, and support for each consumer's recovery.

Quality of Care Finding E.1: CSB substance abuse service providers and the persons they serve experience reliable, trusted, and caring relationships.

- Consumers expressed the following opinions:
    - Seventy-nine percent of consumers say they are satisfied that "staff form a caring and trusted relationship" with them.
    - In response to a question about what they value most about their services at the CSB, 195 consumers listed 72 positive comments related to staff and services.
    - In response to a question about what they value least, only four comments were specifically negative about treatment. Five more comments could be interpreted to be critical of staff or therapeutic issues.
    - Consumers were asked to describe what they (1) most value and (2) least value about services. Of the responses given, 139 were positive and 56 were negative. Of the negative comments: Eight related more to the criminal justice system and the nature of coerced treatment than anything within control of the CSB. Twenty-one related to service scarcity, inconvenience, cost, etc., and did not have to do with the therapeutic relationship.
- Staff expressed the following opinions:
    - Staff was asked to list the three things they most value about their jobs. Of the 487 positive comments that were made by staff, 150 or more of these were explicitly about their respect for their clients, their satisfaction in helping them, the relationships they value with their clients, etc. Less than a dozen of the 425 negative comments that were received could be construed as critical of consumers or the nature of therapy (e.g., group).
- OIG inspectors' impressions drawn from discussions with staff and consumers, assessment of progress notes in records, and observations of staff and consumer interactions support the notion that caring and trusting relationships abound within the CSB substance abuse outpatient services system for adults.

No recommendation

Quality of Care Finding E.2: Staff are employed in their current positions long enough to form trusted, continuing relationships with the consumers they serve.

- Staff reported an average length of service in their current jobs of 5.6 years. This exceeds the average length of service for consumers, which is 1.7 years. Most consumers have experienced a continuing relationship with their primary clinician.
- The 195 consumers who were interviewed were asked what they least value about their services, what services they need that they do not have, and what things they would like

to see change about substance abuse treatment. None of the responses received expressed concern about staff turnover or interruptions in service continuity.

No recommendation

F. Co-occurring Disorders

The preponderance of research reflected now in federal policy holds that mental health and substance abuse needs co-occur more commonly than not and that both conditions should be assessed and treated in an integrated fashion.

Quality of Care Finding F.1: The mental health needs of persons receiving CSB substance abuse outpatient treatment for adults appear to be under assessed and under treated.

The OIG review of CSB substance abuse outpatient services for adults assessed co-occurring treatment issues through record reviews, analysis of organizational structures, and interviews of consumers, staff, and supervisors.

- Assessment of mental health needs:
  - The National Co-Morbidity Study (Harvard University, 2003) estimates that 50 percent of persons with life-long substance use disorders have co-occurring mental illnesses.
  - The National Survey of Drug Use and Health (Substance Abuse and Mental Health Services Administration, 2000) estimates that 50-75 percent of persons in drug treatment programs have co-occurring mental health problems. OIG staff inspected records and sought estimates of the presence of co-occurring mental health problems from staff, supervisors, and consumers at the sample CSBs. Telephone interviews with supervisors at the remaining 15 CSBs were conducted to complete this table:

Total Estimates Of Substance Abuse Service Users With Mental Health Needs			
Staff estimates	**Supervisor estimates**	**Consumer self reports**	**OIG Record Reviews**
70.6%	**75.2%**	**41%**	**45%**

  - OIG inspectors reviewed 239 charts to determine the presence of mental health needs (indicators included client reports, documented staff observations, previous recent service history, referral information, recent psychiatric hospitalizations, and formal evaluations yielding a mental health diagnosis).
    - Forty-five percent of charts contained some indication of mental health needs.
    - Thirty-eight percent of charts contained a DSM mental health diagnosis by a qualified clinician. 79 percent of these were mood disorders (70% depression), 16 percent anxiety disorders, 4 percent schizophrenia or other psychotic disorders, and 2 percent were adjustment disorders.

- Assessment of provision of mental health services:
    - OIG record reviews revealed co-occurring mental health treatment in 34 percent of records.

- Assessment of integration of services and structure of service provision:
    - Staff and supervisors were asked to assess the overall degree of integration of mental health and substance abuse services that their CSB has achieved:

CSB Supervisor and Staff Assessment of Integration of SA and MH Services		
	Staff Estimates*	**Supervisor estimates**
A. Our service teams are fully integrated: mental health and substance abuse needs are met by the same team(s) in a fully coordinated fashion.	26%	27%
B. Most mental health and substance abuse services are organized or even located separately, but there is good coordination and access to services for persons with dual needs.	47%	69%
C. Most mental health and substance abuse services are organized separately and there is poor coordination and poor access to services for persons with dual needs.	28%	4%

***** Staff estimates are based on interviews at the 25 boards visited.

- OIG interviews with supervisors from all CSBs confirm the CSB self assessments shown in the table above:
    - All 40 CSBs offer some form of integrated initial assessment. Whether calling to request mental health or substance abuse services, new clients receive an initial evaluation that addresses both mental health and substance abuse needs to some degree.
    - Eighty-three percent of the CSBs (33 of 40) operate combined mental health and substance abuse divisions with one manager, usually called a clinical services director, overseeing both functions. The remaining 7 CSBs (17%) have separate mental health and substance abuse divisions under separate leadership.
    - However, below the divisional structure, 25 of the 40 CSBs (63%) operate their substance abuse and mental health services as separate teams or units. Effective coordination between two teams within the organization must take place in order to address both the substance abuse and mental health needs.

Quality of Care Recommendation F.1.a: It is recommended that DMHMRSAS provide leadership, guidance, and training to CSBs for the development of integrated treatment models for co-occurring mental health and substance abuse disorders.

DMHMRSAS Response: *DMHMRSAS expanded the Co-Occurring State Incentive Grant and established the Virginia Services Integration Program (VASIP) to provide this leadership. VASIP will continue work supported with funding from the State Infrastructure Development Grant for Individuals with Co-occurring Substance Use and Mental Health Disorders (COSIG), a $3.5 M, five-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). The Commissioner provided guidance to all CSB's in his memorandum of May 23, 2006 that defined the DMHMRSAS commitment to integrated*

service for individuals with co-occurring disorders. This commitment is also reflected in the Integrated Strategic Plan (ISP).

Target date: The federal Grant supporting this activity expires on September 30, 2007. While carry-over funds are anticipated to extend much of the grant funded activity in the next federal fiscal year, much of the project will depend on the momentum of the first three years for the CSBs to continue the objectives of the grant. A budget proposal will be developed by August 2007 to continue staff support for the continued monitoring and training activities. Regardless of funding, the DMHMRSAS is committed to supporting integrated services for the co-occurring population.

Quality of Care Recommendation F.1.b: It is recommended that CSBs study their systems of care to assure maximum integrated response to co-occurring disorders.

DMHMRSAS Comment: DMHMRSAS supports this finding and will work collaboratively with the CSBs to address this recommendation.

Quality of Care Recommendation F.1.c: It is recommended that DMHMRSAS study the extent to which the administrative separation at the state level creates barriers to an integrated response to co-occurring disorders at the provider level.

DMHMRSAS Response: *DMHMRSAS will develop a study team which will consist of the Assistant Commissioner of Community Services, staff from the Office of Substance Abuse Services, staff from the Office of Mental Health Services, representatives of the Mental Health and Substance Abuse Councils of the Virginia Association of Community Services Boards, and the Substance Abuse Advocacy Community to review the impact of the current administrative separation on the provision of local mental health and substance abuse services and make recommendations to address any barrier to the provision of integrated service.*

Target date: DMHMRSAS will complete the study by July 30, 2007.

Quality of Care Finding F.2: Access to psychiatric services and medications for adults receiving substance abuse outpatient treatment services is severely limited at CSBs.

- Staff reports that the average wait for a substance abuse client for a first appointment with a psychiatrist is 34.2 days. Wait times range from a low of 10 days to a high of 82.5 days.
- Staff reports that only about 50 percent of CSBs assign psychiatric time directly to the unit that provides substance abuse outpatient services for adults and that at the remaining CSBs this service is only available through another team, service or service site. Supervisors' estimates are similar - 40 percent assign psychiatrists to the substance abuse treatment team and 60 percent do not. This means that at about half of the CSBs, the clinicians or supervisors of substance abuse services must seek the agreement of another set of service supervisors (usually, mental health services) to arrange a psychiatric evaluation for a substance abuse client.

- Given the scarcity of psychiatric time at most CSBs, some have set priorities for rationing of care, usually for persons with serious mental illness. Substance abuse treatment staff at two of the CSBs that were visited report that psychiatric services are reserved for persons with serious mental illnesses, therefore, substance abuse consumers must go to a community free clinic for psychiatric care.
- Very few CSB substance abuse clients have insurance or any means to pay for prescriptions. Compared to mental health clients, fewer substance abuse clients have had stays in state mental health facilities or otherwise have become eligible for medications through the DMHMRSAS Community Pharmacy. The result is that, CSBs must rely heavily on drug company samples and indigent care programs, local charities, or CSBs purchase of medications.
- Forty seven percent of CSB staff and 37 percent of supervisors say that substance abuse consumers can "usually get their (psychiatric) prescriptions filled free or affordably." Fifty-three percent of staff and 63 percent of supervisors say consumers experience problems getting medications.

Access Recommendations A.1.a and A.1.b are also in support of this finding.

Quality of Care Recommendation F.2.a: It is recommended that DMHMRSAS lead an initiative that will enable a sharing of psychiatric resources between state facilities and CSBs. This will result in maximizing the effectiveness of physicians who are already in the public provider system and will enhance the continuity and quality of care provided in facilities and in the community.

DMHMRSAS Response: *The Inspector General's report on The Virginia Community Services Board Emergency Services Programs contained a similar recommendation. The Department's response to that recommendation indicated that DMHMRSAS' Medical Director would lead an effort to initiate discussion and planning around this issue at the next meeting of the medical directors of state facilities. In addition, the DMHMRSAS Medical Director was to initiate communication with the Virginia Association of Community Psychiatrists to address this issue. DMHMRSAS, state facility and CSB medical leadership, and CSB ESP clinicians will collaborate to examine and implement strategies to make psychiatric consultation accessible to CSB ES programs statewide. On-site consultation will be preferred, but the use of PolyCom and other tele-videoconferencing technology will be utilized to the fullest extent as well. In addition, this group will develop strategies to make training and education more accessible to CSB ES program staff and other key participants in the delivery of emergency services.*

Target date: This effort will be ongoing, and will include periodic assessments of the extent to which access to psychiatric resources has been increased statewide. The Director of the Office of Substance Abuse Services will advise the Medical Director of this recommendation and ask that Substance abuse issues be addressed in this process.

Quality of Care Recommendation F.2.b: It is recommended that DMHMRSAS establish guidelines to enable substance abuse consumers who have been identified by CSBs as

indigent to access free or reduced cost medications through the DMHMRSAS Community Pharmacy.

DMHMRSAS Response: *A number of changes have been made to the Community Resource Pharmacy (CRP). Recent changes make new medications available to meet the needs of consumers not currently served. Guidance from the Assistant Commissioner for Community Services encouraged board leadership to consider expanded medication coverage for substance abuse consumers. DMHMRSAS will conduct assessments or reviews of pharmacy utilization on a quarterly basis in order to proactively identify community / pharmacy needs. This review will also assess how many substance abuse indigent consumers have been able to access medications through the Community Resource Pharmacy.*

Target date: OSAS will develop a budget proposal for the 2008-2010 legislative session to expand funding based on these assessments.

G. Case management

The disease of addiction often is paired with poverty, legal difficulties, housing, employment, and transportation problems. These problems can create seemingly insurmountable obstacles on the road to recovery.

Quality of Care Finding G.1: Consumers of substance abuse services face severe shortages of core services needed for successful recovery in the community – affordable housing, reliable transportation, employment assistance, etc. Very few CSB substance abuse outpatient consumers receive adequate case management assistance.

- In responding to OIG questions about what needs are not being met, consumers identified both substance abuse treatment and community support needs. Responses provided by the 195 consumers who were interviewed included 150 comments regarding community support needs that should be addressed by a case manager. Help with jobs and housing led this list, followed by transportation.
- The Continuum of Substance Abuse Treatment Services Survey completed by all 40 CSBs showed that only 11 (27.5%) of CSBs estimated that they have adequate case management capacity. See Substance Abuse Services Continuum chart in Access Finding A.1 above.
    - Of the 11 CSBs that said they have adequate case management capacity, six were in the study sample. Of these six, two showed markedly more case management service activity than average, four did not.
- OIG staff reviewed 239 records and assessed whether case management needs were documented and whether case management services had been provided in the preceding 90 days:
    - Case management needs were noted in 39 percent of records; no needs were noted in 61 percent of records.
    - Many staff said that they are unable to adequately address case management needs and that they do not therefore fully document community support needs.

OIG inspectors have a concern that an inadequate capacity to perform case management may lead to under identification of needs.

- Approximately 10,500 individuals received case management services through CSB substance abuse programs in FY2005 as reported to DMHMRSAS.
- In the limited number of CSBs where there are dedicated case managers and a high degree of case management activity, review of records and staff and consumer interviews showed the value of vigorous outreach case management to recovering consumers. Consumers experienced greatly increased contacts and supports outside group treatment sessions.
- CSBs without dedicated substance abuse case managers are unable to meet substance abuse clients' case management needs through their existing substance abuse clinicians.
- In the CSB consumer satisfaction survey, the item relating to case management needs ("Staff connect you with community resources to support your recovery, e.g. housing, financial assistance.") drew the largest percentage of critical responses of any item on the scale. 48 percent answered "somewhat satisfied" or "not satisfied".
- Currently there is no source of dedicated funding for case management services to assist those with substance abuse problems. For those with mental illness and mental retardation, Medicaid reimbursement is available for those who are eligible. Though a smaller percentage of substance abuse consumers may need case management and may need a different style or form of case management, OIG findings reveal that very few substance abuse consumers receive the case management help they need.

Access Recommendation A.1.a is also in support of this finding.

Quality of Care Recommendation G.1.a: It is recommended that DMAS investigate the cost and feasibility of covering case management for substance abuse consumers who are Medicaid recipients, focusing particularly on women with children

DMAS Response: *See response to Access Recommendation A.1.b.*

Quality of Care Recommendation G.1.b: It is recommended that DMHMRSAS, working with CSBs, develop a model training curriculum on substance abuse case management and provide training on this topic to CSB staff and supervisors.

DMHMRSAS Response: *DMHMRSAS will link this effort with existing activities, initiated in response to a prior OIG report, that will: (1) define a recovery-oriented, evidence-based case management service model, (2) make recommendations on case manager credentialing, (3) develop caseload standards, if advisable, (4) identify a training curriculum to support implementation of the case management model, and (5) identify resources, including DMHMRSAS staff, needed for sustaining and supporting the recommended model on an ongoing basis. In addition the Substance Abuse workgroup will review the current methods of developing individual service plans (ISPs) and the provision of clinical supervision and make recommendations for a format that is person-centered, reflects the principles of recovery, and meets all regulatory requirements.*

Target date: Convene Workgroup by November 15, 2006. Preliminary recommendations regarding model, credentialing, caseload standards, curriculum and necessary resources will be defined by August 1, 2007. DMHMRSAS will also issue a Request for Proposal that will include development and delivery of curricula to address these topics.

H. Staff qualifications and support

Substance abuse clinicians must have sound clinical knowledge and training regarding a variety of substance abuse and co-occurring treatment issues. They must be supported effectively by their agencies.

Quality of Care H.1: CSB substance abuse staff has appropriate education and training for their positions.

- The majority of CSB substance abuse staff have masters degrees or above.
- A significant number of staff are licensed (LCSW, LPC, etc.) or have specific substance abuse treatment certification (CSAC, LSATP, etc.):

EDUCATIONAL LEVEL OF CSB STAFF							
	High School	Bachelor	Masters	Doctoral		Licensure	SA Certification
CSB Staff	12%	21%	61%	2%		36%	47%
CSB Supervisors	0%	7%	83%	10%		82%	48%

- P&P offices were widely supportive (70% favorable) of the statement "CSB SA staff are competent and well-trained in substance abuse treatment services."
- Traditionally, many substance abuse treatment professionals enter the field having experienced significant personal problems with drug and alcohol problems or have had close family members with serious problems. The following was learned through this review:
    - 27 percent of staff identified themselves as being in recovery from drug or alcohol addiction. Eighty-one of these staff make this fact known to the persons they serve.
    - Sixty-four percent responded that they have been significantly affected by the substance use disorder of a close family member.
    - Consumers who were interviewed often mentioned that they value working with staff members who are in recovery.
- Staff was asked to identify areas in which they feel they need more training in order to be effective. The following were the leading areas identified:
    - Working with persons with Axis II diagnoses 85%
    - Working with persons with serious mental illnesses 82%
    - Working with persons with mental retardation 80%
    - Understanding pharmacological interventions 80%
    - Providing family support/involvement 77%
- Based on record reviews and interviews, OIG staff identified the following additional areas in which training is needed:

- Developing, providing, and documenting person-centered treatment.
- Integrated treatment methods for those with co-occurring substance abuse and mental health disabilities.
- Case management needs assessment, community resources, and the provision of active outreach case management services.

Quality of Care Recommendation H.1.a: It is recommended that DMHMRSAS initiate a collaborative effort with CSBs and consumers to develop training curricula in the following topics and make these programs available to all CSBs:

- Person-centered service planning (See Recommendation C.1.a and C.1.b)
- Provision of integrated treatment for those with co-occurring mental health and substance abuse disabilities. (See Recommendation F.1.a)
- Case management for persons with substance abuse (See Recommendation G.1.b)

DMHMRSAS Response: *See DMHMRSAS response to Recommendation C.1.a and C.1.b, Recommendation F.1., and Recommendation G.1.b. In addition DMHMRSAS plans to conduct a workforce survey in January 2007 to identify training needs generally as well as skills necessary to provide integrated care for co-occurring populations. DMHMRSAS will also issue a Request for Proposal that will include development and delivery of curricula to address these topics. In addition DMHMRSAS will develop a budget proposal to develop a training infrastructure within the Department to support training on delivery of evidence-based and consensus-based practices.*

Target date: OSAS will develop a budget proposal for the 2008-2010 legislative session.

Quality of Care Recommendation H.1.b: It is recommended that each CSB evaluate the training needs of substance abuse treatment staff and take steps to assure that adequate training is made available.

DMHMRSAS Comment: *DMHMRSAS supports this finding and will work collaboratively with the CSBs to address this recommendation. Currently DMHMRSAS provides scholarships to CSBs to attend the Virginia Summer Institute on Addiction Studies. DMHMRSAS participates on the Institute planning committee and will insure that the curriculum reflects the provision of educational material designed to provide training for substance abuse treatment staff. In addition to VSIAS, DMHMRSAS will explore other training platforms (online, regional experiential and didactic) through the training RFP to be published in November.*

I. Services Effectiveness

Through research on service effectiveness, the federal government has identified national standards for best practice and outcome measures. Virginia substance abuse consumers who comply with treatment expectations should expect the success that research indicates will result if evidence-based services are received and adequate service capacity is in place.

This OIG review did not attempt to evaluate the service effectiveness indicator of quality. However, data were collected that show that CSB substance abuse outpatient programs for adults receive positive evaluations from consumers and P&P offices.

In conducting the review, the OIG asked consumers a series questions taken from the National Outcome Measures (NOMs), data that is provided to the federal government. Some NOM data is subject to objective verification (e.g., arrest records), which was not done in this review.

National Outcome Measures (NOMs)			
CSB Consumer Responses	Yes	No	LOS*
How long have you been receiving substance abuse treatment services at this agency?			1.7 years
Since you started receiving services here, has your drug or alcohol use decreased?	91%	9%	
Since you started receiving services here, have you been arrested for any alcohol or drug related offenses?	19%	81%	
Since you started receiving services here, has your employment situation improved or have you stayed employed?	64%	36%	
Since you started receiving services here, has your housing situation become or stayed stable and safe?	86%	14%	

* Length of service involvement

- Consumer interviews included a survey about consumer satisfaction with substance abuse services, 77 percent answered that they were "satisfied" with the "overall helpfulness of the program."
- When asked what they value most about CSB substance abuse services, 195 consumers provided 67 responses that related to positive outcomes on their lives (e.g., being able to open up, live sober, be trustworthy, etc.).
- P&P offices gave favorable ratings of 64 percent to a statement that the substance abuse services provided are "appropriate to the needs of the clients we refer."
- P&P offices gave favorable ratings of 60 percent to a statement that the substance abuse services provided "help my clients recover from substance abuse addiction."
- Almost all services visited featured routine, random breathalyzer and urine screens for drug use. Objective monitoring of drug and alcohol use during treatment is an important principle of effective treatment.

Section IV

Survey of Probation & Parole Offices

The majority of persons served at CSB substance abuse programs have violated the law - underage drinking, DUI, possession or dealing of illegal drugs, theft, robbery, and prostitution to support drug habits, gang and syndicate crime to protect illegal drug trafficking, and others. Crime and substance abuse are paired.

Research has shown that combining criminal justice sanctions with drug treatment can be effective in decreasing drug use and related crime (National Institute on Drug Abuse). CSBs and elements of the criminal justice system are partners in pursuing these goals.

Most CSB adult substance abuse outpatient services are provided to persons who are compelled to be there by some authority. Sixty-six percent of the 239 records reviewed by the OIG showed mandated treatment.

- Some persons are required by the courts to seek treatment for various offenses ranging from drunk driving to drug-related crimes.
- Twenty-one CSBs report that they operate or work with Drug Courts (special courts which focus on drug-related crimes and provide drug treatment for eligible offenders, in lieu of incarceration).
- Some of the consumers are receiving contingent treatment to keep or get their jobs back after a failed drug test, to regain custody of their children after Child Protective Services violations, or to regain driving privileges after losing their licenses.
- The largest referral source for compelled treatment - by far – is the network of 43 local Probation and Parole Offices of the Department of Corrections.

The OIG surveyed all 43 of the local P&P agencies to gather evaluative information about the CSB adult substance abuse outpatient services. Responses were received from 40 (93%) of the agencies.

This survey asked questions about the nature of the relationship between the CSBs and the P&Ps:

RELATIONSHIP BETWEEN COMMUITY SERVICES BOARDS AND PROBATION AND PAROLE OFFICES		
Probation and Parole Survey Responses	**Yes**	**No**
My CSB provides SA treatment services at the P&P office	42%	58%
The P&P contracts and pays for SA services from CSBs	48%	52%
The P&P operates its own SA services	43%	58%

While survey responses related to the quality of CSB substance abuse services can be found throughout this report, the chart that follows summarizes all service quality information collected from the P&P offices:

P&P Survey Responses to Service Qualities of CSBs					
	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
Good Working Relationship with CSB SA leadership	2%	0%	16%	39%	43%
SA staff are competent and well trained in SA	0%	5%	28%	30%	40%
SA staff are courteous and professional in dealing with our office	2%	2%	14%	39%	43%
CSB is able to accept new referrals into treatment with little delay	12%	21%	14%	42%	12%
SA treatment is appropriate to the needs of the clients we refer	0%	18%	21%	40%	23%
Clients report that CSB SA staff are caring and supportive	0%	10%	26%	33%	31%
Clients report that CSB SA staff treat them with dignity and respect	0%	8%	25%	30%	38%
CSB charges appropriate and fair fees to indigent clients	5%	7%	26%	49%	14%
CSB staff accept and work well with the mission and requirements of P&P system.	2%	9%	33%	33%	23%
I believe CSB SA services help my client recover from SA addiction	2%	12%	24%	34%	27%
CSB fully meets the SA service needs of my community	9%	12%	35%	30%	14%

P&P offices were asked to list the areas of greatest strength, weakness, and greatest needs of the CSB substance abuse service system:

Probation and Parole Office Survey Responses
Areas of Strength of the CSBs
• Cooperation between agencies • Ease of referral • Quality of services even if offerings are limited and/or basic
Areas of Weakness of the CSBs
• Wait time for access to services for newly-referral clients • CSB staff turn over and vacancies • Lack of resources for program expansion
Areas of Greatest Need for the System
• Expansion of the range and capacity of substance abuse services, including inpatient/residential treatment, intensive outpatient and detox services • Increased access to housing and supported living arrangements. • Services to sex offender population

Section V

Appendix

A. Capacity of Outpatient Substance Abuse Services as Reported by CSBs

B. CSB Substance Abuse Services for Which Capacity has Decreased Over Past Six Years

C. Survey Questionnaires and Checklists
(Documents are available in the website version of this report found at www.oig.virginia.gov)

Attachment A - Capacity of Outpatient Substance Abuse Services as Reported by CSBs

	Detoxification Services					Outpatient Treatment							Case Mgt	Srvs in Crim Jus Sym		
	Medical Detox	Social Detox	Medically Assited Outpatient Treatment			Day Treatment	Intensive Outpatient	Group	Individual	Educational/ Orientation Groups	Family Support and Therapy	Aftercare or follow-up	Outreach Assistance	Jail or Prison Based	Community -based	Drug Court or family Drug Court
			Agonist Maintenance	Partial Agonist	Medically Assited											
Alexandria																
Alleghany Highlands																
Arlington																
Blue Ridge																
Central Virginia																
Chesapeake																
Chesterfield																
Colonial																
Crossroads																
Cumberland Mountain																
Danville-Pittsylvania																
Dickenson																
District 19																
Eastern Shore																
Fairfax-Falls Church																
Goochland-Powhatan																
Hampton-Newport News																
Hanover County																
Harrisonburg-Rockingham																
Henrico Area																
Highlands																
Loudoun																
Middle Peninsula-NN																
Mt. Rogers																
New River Valley																
Norfolk																
Northwestern																
Piedmont																
Planning District One																
Portsmouth																
Prince William																
Rappahannock Area																
Rappahannock-Rapidan																
Region Ten																
Richmond Behavioral H. A.																
Rockbridge																
Southside																
Valley																
Virginia Beach																
Western Tidewater																

No Capacity – White Area Inadequate Capacity – Light Grey Adequate Capacity – Dark Grey

Attachment A - CSB Substance Abuse Services Residential Capacity

	Long Term			Short Term			Half Way House			Oxford House			Subsidized Housing
	Men	Women	Women and Children	Men	Women	Women and Children	Men	Women	Women and Children	Men	Women	Women and Children	
Alexandria													
Alleghany Highlands													
Arlington													
Blue Ridge													
Central Virginia													
Chesapeake													
Chesterfield													
Colonial													
Crossroads													
Cumberland Mountain													
Danville-Pittsylvania													
Dickenson													
District 19													
Eastern Shore													
Fairfax-Falls Church													
Goochland-Powhatan													
Hampton-Newport News													
Hanover County													
Harrisonburg-Rockingham													
Henrico Area													
Highlands													
Loudoun													
Middle Peninsula-NN													
Mt. Rogers													
New River Valley													
Norfolk													
Northwestern													
Piedmont													
Planning District One													
Portsmouth													
Prince William													
Rappahannock Area													
Rappahannock-Rapidan													
Region Ten													
Richmond Behavioral H. A.													
Rockbridge													
Southside													
Valley													
Virginia Beach													
Western Tidewater													

No Capacity – White Area Inadequate Capacity – Light Grey Adequate Capacity – Dark Grey

Attachment B - Services That Have Decreased over the Past Six Years According to CSB Survey Data

	Detoxification Services					Outpatient Treatment							Case management	Services to Persons in Criminal Justice			Susbtance Abuse Residential Services													
	Medical Detox	Social Detox	Medically Assited Outpatient Treatment			Day Treatment	Intensive Outpatient	Group	Individual	Educational /Orientation Groups	Family Support and Therapy	Aftercare or follow-up	Outreach Assistance	Jail or Prison Based	Community -based	Drug Court or family Drug Court	Long Term			Short Term			Half Way House			Oxford House			Subsidized Housing	TOTAL
			Agonist Maintenance	Partial Agonist	Medically Assisted												Men	Women	Women and Children	Men	Women	Women and Children	Men	Women	Women and Children	Men	Women	Women and Children		
Alexandria																														0
Alleghany Highlands																X	X	X												3
Arlington																													X	1
Blue Ridge						X	X		X	X		X	X				X	X												8
Central Virginia						X	X																							2
Chesapeake	X	X			X														X	X	X		X	X		X	X			10
Chesterfield								X	X			X	X		X	X				X	X		X	X		X	X	X		13
Colonial						X	X	X	X	X																				5
Crossroads	X							X	X	X		X			X					X	X		X							9
Cumberland Mountain	X																													1
Danville-Pittsylvania																	X	X	X											3
Dickenson	X		X								X			X						X	X									6
District 19																														0
Eastern Shore																														0
Fairfax-Falls Church	X					X	X	X	X		X	X	X	X						X										10
Goochland-Powhatan		X			X			X	X	X	X		X																	7
Hampton-Newport News						X	X	X	X	X							X	X	X	X	X	X	X	X	X			X	X	16
Hanover County	X																													1
Harrisonburg-Rockingham	X					X	X				X			X			X	X		X	X		X	X		X			X	13
Henrico Area	X					X	X		X			X	X							X	X									8
Highlands																														0
Loudoun																		X	X	X	X	X								5
Middle Peninsula-NN																														0
Mt. Rogers																														0
New River Valley	X			X										X	X															4
Norfolk	X		X	X		X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	25
Northwestern									X			X		X						X	X									5
Piedmont	X								X	X	X	X					X	X	X	X	X	X		X	X				X	14
Planning District One	X													X	X						X	X								5
Portsmouth																														0
Prince William	X		X					X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X					19
Rappahannock Area																														0
Rappahannock-Rapidan	X					X	X	X	X	X	X	X	X			X															10
Region Ten											X					X				X			X							4
Richmond Behavioral H. A.	X					X	X	X					X						X	X	X	X	X	X						12
Rockbridge	X							X	X	X	X			X	X															7
Southside																														0
Valley									X					X										X						3
Virginia Beach		X			X			X	X						X					X	X					X	X			9
Western Tidewater																														0
Total	**16**	**3**	**3**	**2**	**3**	**10**	**10**	**12**	**16**	**10**	**10**	**9**	**9**	**10**	**10**	**2**	**8**	**10**	**8**	**16**	**15**	**7**	**9**	**9**	**4**	**5**	**4**	**4**	**4**	**238**

Office of the Inspector General

Continuum of Substance Abuse Treatment Services – Survey of Community Services and Capacity

Please answer the questions below about your community's substance abuse services network.

The questionnaire is in the form of an MS Word document. Complete your questionnaire and save it to your hard drive, then send it as an attachment to John Pezzoli. mailto:john.pezzoli@oig.virginia.gov. If you have any questions, email or call John Pezzoli at 804-840-3092.

Services are arranged, roughly, in terms of increasing intensity and structure, with least restrictive services beginning at the bottom of the chart. As some services may often be precursors or follow up to treatment, e.g., detoxification services or half way houses, their placement in the structure may not reflect the typical order of service occurrence.

Answer for services that are directly operated by your CSB, contracted by your CSB, or affordably available to indigent consumers. All services should ideally be available in your community or in reasonable range for the persons you serve and their families – this judgment is up to you, based on consumer convenience and treatment effectiveness (a wider range of access is allowed for long term residential services). Services must be affordably available to the indigent clients CSBs serve.

The survey also asks you to assess the capacity of services to meet local needs. Limits on capacity would reflect limited available space or funding. If a private service offers some indigent care, available and used by CSB clients, list it as an available service, but assess its capacity based on availability of affordable care.

Name of Community Services Board:

Contact Person (Name, Telephone, and email address):

	Check only one box				
Substance Abuse Services Continuum Indicate whether your community has these services available, according to the instructions above, and assess their capacity to meet the needs of your community. Please place your marks in the un-shaded boxes opposite your choices.	**Service is not available**	**Service available, but capacity is inadequate**	**Service available, capacity adequate**	**Has the capacity of this service been decreased in the last 10 years (put an X in only one box) (if the service has been closed, check yes)**	
RESIDENTIAL SERVICES				**YES**	**NO**
Residential Treatment – Long Term. 24 hour, long term (6-12 months).					
• For men					
• For women					
• For women and their children					
Residential Treatment – Short Term. 24 hour, shorter term (1-6 months).					
• For men					
• For women					
• For women and their children					
Half Way House - Partially supervised, transitional (e.g., may be a step down from more intensive treatment)					
• For men					
• For women					
• For women and their children					
Oxford House – Resident-supported, unsupervised group living arrangement.					
• For men					
• For women					
• For women and their children					
Subsidized individual apartment living arrangements – may feature case management/visiting staff supports.					

	Check only one box				
DETOXIFICATION SERVICES	**Service is not available**	**Service available, but capacity is inadequate**	**Service available, capacity adequate**	**Has the capacity of this service been decreased in the last 10 years (check one)**	
				YES	**NO**
Medical Detoxification - individuals are systematically withdrawn from addicting drugs in an inpatient, residential, or outpatient setting, under the supervision of medical personnel and with the assistance of medications. Usually a precursor to treatment.					
Social Detoxification - individuals are systematically withdrawn from addicting drugs in a residential or outpatient setting, without the use of medications. Usually a precursor to treatment.					
Medically Assisted Outpatient Treatment					
Agonist Maintenance Treatment – Outpatient treatment of opiate addicts using synthetic opiate medication, usually methadone. Offered in conjunction with individual or group counseling.					
Partial Agonist or Antagonist Treatment – Outpatient treatment of opiate addicts using Buprenorphine (or other new medications). Offered in conjunction with individual or group counseling.					
Medically assisted Treatment – Outpatient treatment using medications (e.g., Naltrexone) that reduce craving . Offered in conjunction with individual or group counseling.					

	Check only one box				
	Service is not available	**Service available, but capacity is inadequate**	**Service available, capacity adequate**	**Has the capacity of this service been decreased in the last 10 years (check one)**	
				YES	**NO**
Outpatient Treatment – Drug Free					
Day Treatment – Intensive, continuous outpatient treatment and supports, 5-7 days a week, over 2 hours per day. Group treatment emphasis.					
Intensive Outpatient Treatment – Intensive, frequent outpatient treatment and supports, 3-4 days a week, 1-2 hours per day. Group treatment emphasis.					
Outpatient treatment - group treatment, 1-2 times a week, 1-2 hours per day.					
Outpatient treatment – individual, 1-2 times a week.					
Psycho-educational/orientation groups such as ASAP level 1					
Family support therapy – Support and educational services offered to families of persons in treatment.					
Aftercare or follow along treatment – Opportunities for ongoing, recurring, self-selected support opportunities for persons in advanced recovery.					
Case Management					
Ongoing outreach assistance with information, referral, services coordination, assistance with meeting instrumental needs (financial assistance, medical care, housing, transportation, job training, etc.)					

Services to Persons in the Criminal Justice System (may include some of the services listed above, e.g., intensive outpatient, but evaluate as a separate service offering in this section)					
Jail or prison-based treatment programs – Intensive services to incarcerated persons, usually separated from the general inmate population, best if coordinated with post-release treatment.					
Community-based treatment for criminal justice populations – Individual and group outpatient treatment contracted by probation and parole at the CSB or at the P&P office.					
Drug court or family drug court services – Criminal justice diversion and treatment services for persons convicted of drug-related crimes.					

Office of the Inspector General
CSB Adult Substance Abuse Outpatient Services Record Review

CSB _____ Contract Agency (if applicable)_____Consumer Initials: _____

Reviewer _____ SA Staff Initials: _____

Date _____

1. **Value: The development of need assessments, treatment plans, and the conduct of treatment are consumer centered and consumer driven.** Select the option that most closely fits what the plan presents with regard to choice and self-determination:

_____ There is no record of consumer involvement with the ISP and the conduct and direction of treatment, except for the signature. It seems that the SA outpatient staff member wrote the plan and (perhaps) explained it to the consumer and asked him or her to sign it. The plan and treatment notes are about the consumer, with little evidence that the consumer helped to shape or direct them.

_____ There is evidence that the SA outpatient staff member elicited and received input from the consumer about the plan. The plan was written by the SA outpatient staff member, but with real consumer input and partnership. The consumer's own goals for treatment are clearly identified.

2. Does this CSB stand out in terms of empowering and involving consumers in treatment? If so, briefly summarize methods used as a possible best practice to be noted:

3. Has this consumer been referred by an element of the criminal justice system to receive mandatory treatment?

_____Yes _____No

4. Is there evidence of co-occurring disability and service integration?

	Yes	No	NA	Diagnosis
A. Is there a mental health status evaluation?				
B. Is there clinical evidence of serious mental health complaints or issues?(e.g., consumer reports, staff observations, family reports, referral info)				
C. Is there a documented mental health diagnosis?				
D. If yes, what is the mental health diagnosis?				
E. Are there co-occurring mental health services being provided?				
F. Is the ISP integrated with regard to MI/SA issues/services?				

5. Evidence that the coordination or assistance with community support services (case management) has occurred in the last quarter (check all that apply):

Does the consumer have significant needs in one or more of these areas? _____ yes _____ no

A. arrangement of medical services	
B. arrangement of housing assistance	
C. advocacy for consumer	
D. crisis support services	

E. job or job training support or assistance	
F. assistance with benefits or financial aid	
G. arrangements for child care (for treatment, job, etc.)	
H. arrangements for transportation	

Adult Substance Abuse Outpatient Services Review
Substance Abuse Service Users Interview

CSB/Agency _____

Date _____

1. How long have you been receiving substance abuse treatment services at this agency? If you have left and re-entered treatment one or more times, add up all the time together.

_____ years _____ months

2. Since you started receiving services here, has your drug or alcohol use decreased?

Yes _____
No _____

3. Since you started receiving services here, have you been arrested for any alcohol or drug related offenses?

Yes _____
No _____

4. Since you started receiving services here, has your employment situation improved or have you stayed employed?

Yes _____
No _____

5. Since you started receiving services here, has your housing situation become or stayed stable and safe?

Yes _____
No _____

6. Are you receiving services at this agency either under a court order or by referral from a criminal justice system agency (e.g., drug court, probation or parole, sentencing agreement, etc.)?

Yes _____
No _____

7. How long did you have to wait from the first time you called this agency to the day you actually began to receive treatment services? ***(listen carefully to the explanations given by the interviewer)*** _____days

8. What do you value most about the services you are receiving from this agency?

9. What do you value least about the services you are receiving from this agency?

10. What substance abuse services do you need – but are not getting – that would help with your recovery from drug or alcohol abuse?

11. What community support services (e.g., housing, job) do you need – but are not getting – that would help with your recovery from drug or alcohol abuse?

12.

How satisfied are you with the services you are receiving here? **Check one box for each of the items below**	**Satisfied**	**Somewhat Satisfied**	**Not Satisfied**
A. The agency has been welcoming and supportive from the start?			
B. The professionalism and knowledge of the staff?			
C. Staff form a caring and trusting relationship with you?			
D. Staff treat you with dignity and respect?			
E. Staff show hope and belief that you can recover from addiction?			

How satisfied are you with the services you are receiving here? **Check one box for each of the items below**	**Satisfied**	**Somewhat Satisfied**	**Not Satisfied**
F. Staff are sensitive to your ethnic & cultural background?			
G. The rules and policies of the program are fair?			
H. The fees they charge you are affordable?			
I. Staff explain your rights and responsibilities?			
J. Staff help you develop a long-term personal recovery plan?			
K. Staff connect you with community resources to support your recovery (e.g. housing, financial assistance)?			
L. The cleanliness and safety of the facility?			
M. The overall helpfulness of the program?			

13. Do you feel you have mental health needs or issues such as severe or persistent depression or anxiety, hearing voices, etc. along with your drug or alcohol addiction?

Yes _____

No _____ ***If you answer "No" go on to question number 14.***

If yes, are you getting help for these problems (e.g., seeing a psychiatrist, other doctor, or therapist for these needs?

Yes _____

No _____

If you are seeing a psychiatrist, doctor, or therapist for mental health needs, is she/he

_____ your regular therapist who also works with you on drug or alcohol issues?

_____ someone else, but he/she is a part of the same team and this same site that works with you on your drug or alcohol issues?

_____ someone at another team or site, such as a mental health office, not the same team that works with you on your drug or alcohol issues?

How satisfied are you with how the agency has met your mental health needs?

____ satisfied ____ somewhat satisfied

____ not satisfied ____ not applicable

14. Which of these choices best describes how your treatment plans and goals are developed. ***Pick only one***.

A. My clinician (staff) develops my treatment plans and goals, explains them, and asks me to sign them. I don't have much to do with it. (Note: there could be requirements from Probation and Parole or a court that must be in your treatment plan.)	
B. My clinician (staff) involves me in developing my treatment plans and goals. We do it together and I have a say in it. (Note: there could be requirements from Probation and Parole or a court that must be in your treatment plan.)	
C. I play the biggest role in developing my own treatment plans and goals. Staff may help or guide me, but I feel like I have designed my own recovery plan. (Note: there could be requirements from Probation and Parole or a court that must be in your treatment plan.)	

15. What one or two changes do you think are most needed to improve substance abuse treatment services in Virginia?

Office of the Inspector General
CSB Adult Substance Abuse Outpatient Services Review

Supervisor Interview

(shaded items are instructions to the interviewer)

CSB: _____Contract Agency(if applicable):_____

Reviewer: _____ Respondent: _____

Date: _____ Phone: _____

Respondent: (circle only one)

SA Outpatient Supervisor MH/SA Outpatient Supervisor Intake Supervisor

SA Division Director MH/SA Division Director

Other_____

1. How long have you been in a position that supervises adult substance abuse outpatient services at this CSB(agency)? _____years

2. Highest level of education: (circle one only)

   ___High School ____Bachelors ____Masters ____Ph.D.

3. Licensure? (LPC,LCSW, etc.) ___yes ___no

4. Substance Abuse Certification? (CSAC, CSAC-Asst, LSATP) ___yes ___no

5. What do you do to assure or increase consumer choice, consumer participation, and self-determination in SA outpatient services?

6. How is your agency organized with regard to provision of SA and MH outpatient services? Brief overview – ***integrated, coordinated, or separate***? Refer to organizational chart (which has been requested in advance).

NOTE: ***We only need to ask question 7 below of one of the supervisors*** – the one who supervises intake/access. Pick most appropriate person based on division director interview, org chart, etc..

7. Read or paraphrase: We want to understand how your access system works for SA outpatient services.

   How does a person – ***new to your services*** – enter services to receive substance abuse treatment? (advise the respondent not to jump ahead or make observations – we're going to take it step by step and we don't want to repeat):

- What number do they call, is it a separate number for SA or MH services or an integrated access center?

- Must the person call himself, or is there an allowance for referral from an agency that mandates treatment? How do you handle P&P referrals, for example?

  Do you do access/initial evaluation ***at*** the P&P? yes or no

- When the first call comes in, what is done on the phone?

- Where and for what is a person who calls the published number and requests SA services first directed?

- What happens there? (it may be a clinical evaluation or merely a financial, or a drop-in intake group, etc.)

  - How long does it take – ***now*** – from the call to *this* appointment?

  - What happens after this?

- Describe the first comprehensive clinical evaluation.

- Where and when (organizationally, time line) does it take place?

- Who does it, what are their qualifications, are they MH, SA or cross-qualified staff?

- How long after the first call does it take to get this evaluation? (Is it different than the initial appointment, above?

- How is the person then referred for SA treatment (note: it may be the first step in treatment, at an SA treatment team?

- How long, on average, do the persons you serve have to wait to begin treatment ***from the day they make their first call to your agency to the day they start active treatment services*** (not an intake or access interview, but ongoing treatment) ?

  _____ days

  This is the key question in this session – comparable to the same one asked of staff, stakeholders, and clients. Get the answer in days and make it clear: first call to actual treatment, not anything else.

- If an MH need, as well as SA needs were presented or discovered during the initial assessment, what would happen?

Explain: Now we are asking about ongoing service provision. The person is receiving SA outpatient treatment and needs MH services.

8. What co-occurring conditions occur in your SA outpatient service population? Please estimate.

What percentage of the persons you now serve in SA treatment also have emotional or mental health problems such as depression or anxiety (continuing and severe, rather than situational or transitional)?	
What percentage of the persons you now serve in SA treatment also have serious, persistent, and disabling mental illnesses such as schizophrenia or bipolar disorder?	
What percentage of the persons you now serve in SA treatment also have an Axis II diagnosis such as borderline personality disorder?	
What percentage of the persons you now serve in SA treatment also have a diagnosis of mental retardation?	

9. How do SA outpatient treatment clients access psychiatric services (e.g., psychiatrist, doctor, or nurse practitioner, nursing services) when it is deemed necessary? Check only one option

_____psychiatric time is assigned to SA treatment teams, at those sites, controlled by the SA or integrated treatment service leaders – not another service division.
_____we refer SA clients needing psychiatric services to another team or site (e.g., a mental health or medical director-administered services).
Comments?

10. How would you describe your indigent clients' access to psychiatry services. Consider waiting time, challenges to referrals, etc.

_____good_____fair_____inadequate

11. How would you describe your indigent (non-insured) clients' access to medications that are prescribed by your CSB's physicians – include both psychiatric and addiction treatment medications – pharmacological interventions).

Access to Medications	**good** (they usually can get the prescriptions filled free or affordably)	**fair** (they only get some of the prescribed medications due to cost)	**inadequate** (they rarely or never can get free or affordable meds)	**NA**	**Source of medications** enter primary source (s): 1-CSB purchase 2-aftercare pharmacy 3–samples 4-charities
psychiatric medications					
pharmacological interventions for treating addictions					

12. How would you assess the integration of your agency's substance abuse and mental health services? pick only one

_____our service teams are fully integrated: mental health and substance abuse needs are met by the same teams in a coordinated fashion.

_____most mental health and substance abuse services are organized and maybe supervised separately, but there is good coordination and access to services for persons with dual needs

_____most mental health and substance abuse services are organized separately and there is poor coordination and poor access to services for persons with dual needs. Clients with co-occurring disorders may be unrecognized, or may fall between the cracks.

13. Which of these choices best describes how consumers' treatment plans and goals are developed. Pick only one.

Clinician develops individual services plan (ISP) for the consumer, explains it, and asks consumer to sign it. (Note: ISP may include requirements from criminal justice system referral sources, e.g., probation and parole.	
Clinician involves consumers in developing their ISP, inviting the consumer to help create goals. (Note: ISP may include requirements from criminal justice system referral sources, e.g., probation and parole.	
Consumers substantially lead the development of their own need assessment and ISP, in their own words, with staff supports. (Note: ISP may include requirements from criminal justice system referral sources, e.g., probation and parole.	

14. How do SA outpatient clients have their needs addressed after regular office hours and in crises?

How well does this meet your clients' needs, what are the gaps?

15. What SA treatment services does your community most need to meet SA service needs more completely?

A. Services that you have, but need greater capacity:

B. Services that do not exist:

16. What community support services (e.g., housing, jobs) does your community most need to meet SA service needs more completely?

A. Services that you have, but need greater capacity:

B. Services that do not exist

17. Here is the Vision Statement of the DMHMRSAS:

Our vision is of a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation in all aspects of community life including work, school, family and other meaningful relationships.

	very well	okay	not very well
Does this vision statement describe SA treatment services at your CSB?			
Is it suitable and appropriate for SA services?			

Comments:

18. What one or two changes do you think are most needed to improve substance abuse treatment services in Virginia?

Adult Substance Abuse Outpatient Services Review

Staff Interview

CSB/Agency _____

Date _____

1. How long have you served?

   A. In your current job _____years ____months

   B. In SA services at your current agency _____years ____months

   C. In SA services overall, in your career _____years ____months

2. What three things do you value most about your current position?

   A.

   B.

   C.

3. What three things do you value least about your current position?

   D.

   E.

   F.

4. Are you a person in recovery from a substance use disorder? ___yes ___no

   If yes, do you make this known to the persons you serve? ___yes ___no

5. Have you been significantly affected by a close family member who has experienced a serious substance use disorder? ___yes ___no

6. Highest level of education: (circle one only)

   ___High School ____Bachelors ____Masters ____Ph.D.

7. Licensure? (LPC,LCSW, etc.) ___yes ___no

8. Substance Abuse Certification? (CSAC, CSAC-Asst, LSATP) ___yes ___no

9. Please respond to the items regarding training and support needs in the following grid.

Service Populations/Service Models	**Training in the last 24 months?** Yes/No	**Agency guides** **and supports you effectively** (e.g., through supervision, policies, etc.) 1. poor 2. fair **3.** good	Need more training to be effective 1. low or no need **2.** moderate need **3.** high need
A. working with the criminal justice system – court ordered treatment, reports to P&P, etc			
B. working with persons with SA issues and emotional problems such as depression or anxiety			
C. working with persons with SA issues and serious mental illnesses such as schizophrenia and bi-polar disorder.			
D. working with persons with Axis II diagnoses such as borderline personality disorder.			
E. working with persons with dual diagnoses of SA and mental retardation			
F. using Motivational Enhancement Therapy			
G. understanding the role of pharmacological interventions (Naltrexone, buprenorphine, etc.)			
H. using auricular acupuncture			
I. providing family support/involvement services			
J. knowledge of community resources and supports (e.g., housing, job training, transportation, financial assistance)			
K. Using MRT – Moral Reconation Therapy			

10. How long, on average, do the persons you serve have to wait to begin treatment ***from the day they make their first call to your agency to the day they start active treatment services*** (not an intake or access interview, but ongoing treatment) ?

_____ number of days elapsed from first call to agency to start of treatment

11. What **SA treatment services** does your community most need to meet SA needs?

A. Services that you have, but need greater capacity:

B. Services that do not exist:

12. What **community support services** (e.g., housing, jobs) does your community most need to meet SA needs more completely?

A. Services that you have, but need greater capacity:

B. Services that do not exist

13. Identify the drugs or other abused substances that most often occur with the population you serve here. Check only one column for each drug.

Frequently Abused Substances	**Frequently seen**	**Occasionally seen**	**Rarely seen**
A. alcohol			
B. opiates (heroin, OxyContin)			
C. barbiturates/sedatives (Quaalude, mytal, Nembutal)			
D. amphetamines/methamphetamines (meth, speed, crystal meth)			
E. cocaine/crack			
F. marijuana/hashish			
G. hallucinogens (LSD, peyote)			
H. inhalants (gasoline, paint thinner, etc.)			
I. over the counter medications (cough syrup, etc.)			
J. tranquilizers (benzos, ativan, Xanax, Valium)			
K. PCP (angel dust)			
L. club drugs (ecstasy, etc.)			

14. Please list any of the drugs in the above table for which you have seen an increase in usage in the last 1-2 years.

_____

15. To what degree are co-occurring treatment needs seen in your caseload? Please estimate the percentage of the persons you now serve in SA treatment who also have:

A. Mental health problems such as depression or anxiety (continuing and severe, rather than situational or transitional)?	_____%
B. Serious, persistent and disabling mental illnesses such as schizophrenia or bipolar disorder?	_____%
C. Significant Axis II traits such as borderline, narcissistic, or antisocial personality disorder?	_____%
D. Mental retardation?	_____%

16. How would you describe the integration of your agency's substance abuse and mental health services? ***Check one option:***

A. _____Our service teams are fully integrated: mental health and substance abuse needs are met by the same team(s) in a fully coordinated fashion.

B. _____Most mental health and substance abuse services are organized or even located separately, but there is good coordination and access to services for persons with dual needs

C. _____Most mental health and substance abuse services are organized separately and there is poor coordination and poor access to services for persons with dual needs.

17. How do the persons you serve access psychiatric services (e.g., psychiatrist, doctor, or nurse practitioner, nursing services) when it is deemed necessary? ***Check one option:***

A. _____Psychiatric time is assigned here, at and by our SA treatment team

B. _____We refer clients needing psychiatric services to another team or site (e.g., mental health services, medical services)

18. How long must an SA treatment client wait for a first appointment with psychiatry services?

_____ days

19. How would you describe your indigent clients' access to medications that are prescribed by your CSB's physicians.

A. _____good (they usually can get the prescriptions filled free or affordably)

B. _____fair (they only get some of the prescribed medications due to cost)

C. _____inadequate (they rarely or never can get free or affordable meds)

Please go to the nest page

20. Which of these choices best describes how consumers' treatment plans and goals are developed. **Pick only one**.

A. Clinician develops individual services plan (ISP) for the consumer, explains it, and asks consumer to sign it. (Note: ISP may include requirements from criminal justice system referral sources, e.g., probation and parole.	
B. Clinician involves consumers in developing their ISP, inviting the consumer to help create goals. (Note: ISP may include requirements from criminal justice system referral sources, e.g., probation and parole.	
C. Consumers substantially lead the development of their own need assessment and ISP, in their own words, with staff supports. (Note: ISP may include requirements from criminal justice system referral sources, e.g., probation and parole.	

21. What one or two changes do you think are most needed to improve substance abuse treatment services in Virginia?

Office of the Inspector General for Mental Health, Mental Retardation, and Substance Abuse Services

Survey Regarding CSB Adult Substance Abuse Outpatient Services
Stakeholder Survey
DOC Probation and Parole Office Chiefs

The Office of the Inspector General for Mental Health, Mental Retardation, and Substance Abuse Services (OIG) is established in the Office of the Governor by the Code of Virginia § 37.2-423. Its purpose is to inspect, monitor, and review the quality of services provided or licensed by the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services. The OIG makes recommendations to the Office of the Governor, the members of the General Assembly, and the Joint Commission on Healthcare.

The OIG is currently studying the adult substance abuse (SA) services provided by Virginia's community services boards (CSBs) and, in some communities, agencies with which the CSB may contract to purchase these services. This study will include site visits to the programs, interviews with clients, and input with key stakeholders. Virginia's local probation and parole system is a key stakeholder in the publicly funded substance abuse services system, providing as many as 60 percent of referrals to CSB SA programs. The perspective of local probation and parole staff regarding these services is an important element in evaluating the services.

This survey is concerned with adult drug and alcohol outpatient treatment services only. Please do not respond for children's services, mental health services, etc. Input will be collected from all jurisdictions of Virginia. Data will be aggregated and not identified by source, but we do ask for identifying information so that we may follow up with you if needed.

Some probation and parole offices may fall within the jurisdiction of more than one CSB. In these cases, please make copies of the questionnaire and complete one for each CSB with which you regularly interact.

The questionnaire is designed in Microsoft Word table. Simply enter your data in the boxes provided (they will expand as needed to fit your content). After completing the questionnaire(s), save it as a Word document, then attach it to an email to and send to john.pezzoli@oig.virginia.gov .

If you have questions about how to complete the survey, please contact john.pezoli@oig.virginia.gov or call 804-840-3092.

Please complete and return this survey by August 1, 2006.

1.	Name of Probation and Parole Office. Please include contact person, telephone number, and email	

2.	Name of Community Services Board that serves your area. (If services are contracted, please name the agency you work with for SA outpatient services)	

3. Please rate the CSB's Adult Substance Abuse Outpatient Services on a scale of 1 to 5, with 1 being the lowest, most critical rating, and 5 being the highest, most positive rating. For some questions these ratings may be an indication of your agreement with a statement, e.g., 1= strongly disagree; 5=strongly agree. Check only one box per line:

CSB service qualities (respond for CSB-contracted agency identified above, if applicable)	**1**	**2**	**3**	**4**	**5**
Our office has a good working relationship with the CSB SA leadership					
CSB SA staff are competent and well trained in SA treatment services					
CSB SA staff are courteous and professional in dealing with our office					
CSB is able to accept new referrals into treatment with little delay					
CSB SA treatment is appropriate to the needs of the clients we refer					
My clients report that CSB SA staff are caring and supportive					
My clients report that CSB SA staff treat them with dignity and respect					
The CSB charges appropriate and fair fees to indigent clients					
CSB staff accept and work well with the mission and requirements of the P&P system.					
I believe CSB SA services help my clients recover from SA addiction					
The CSB fully meets the SA service needs of my community					

Please add any comments you wish about any of these items:

4.

CSB/P&P Service Relationship	Yes	No	NA
My CSB provides SA treatment services at the P&P office.			
The P&P contracts and pays for SA services from the CSB (regardless of location)			
The CSB provides SA services to P&P clients without charge to the P&P office (it may charge clients on a sliding scale basis).			
The P&P office operates its own SA services.			

5. Waiting time to enter services.

Please estimate how many days typically elapse between the time a client first calls (or your staff make a referral) and the client actually begins to receive treatment services (not intake or access, or placement interview, but actual, ongoing treatment) at the CSB?	

6. Strengths

What does your office value most about the CSB's SA services?

7. Weaknesses

What does your office value least about the CSB's SA services?

8. Needed services

What services are most needed by the clients you serve that are not offered in your community?